

**LONG TERM CARE & HOME HEALTH EMERGENCY MANAGEMENT COLLABORATIVE
(LTCHHEMC)**

Workshop - SEPTEMBER 23, 2011

INTRODUCTIONS AND PURPOSE

Gap Analysis for 3 National Planning Scenarios

- Scenario 10: Natural Disaster – Major Hurricane
- Scenario 3: Biological Disease Outbreak – Pandemic Influenza
- Scenario 2: Biological Attack – Aerosol Anthrax
- Decision on content and date of next meeting

SCENARIO 10: NATURAL DISASTER – MAJOR HURRICANE

- Hurricane Ike was a Category 2 storm
 - Storm surge is directly related to the diameter of the storm. The bigger the radius, the bigger the surge
 - The size of the storm surge is multi-variant
- Time
 - Cone of potential landfall areas arise
 - When sizable hurricane is headed towards Texas:
 - Begin looking at emergency plans and kits
 - Potential evacuation, decision to stay or go
- Emergency Measures/Concerns of the past:
 - When patients arrive at long-term healthcare facilities, forms should be filled out so that it is determined immediately what the status of that patient is, whether they need to be evacuated, can access electricity, etc. To keep track of patients, all are sent to one facility. Nurses and medical equipment all sent to one facility. In the past, some patients were sent to medical care centers that could not provide the type of services they needed.
 - One hospice has an emergency plan, emergency vests to identify patients with medical needs, out-of-state contact persons, emergency form for each patient, etc.
 - Large concern: having patients be sent to shelters in which they are accounted for and cared for. Systems exist to address lost patients – wristbands, Radiant. It's important to not have everyone rely on the same contractors – who are overloaded during emergency. Spread out the services. Many long-term care facilities had agreements/MOUs with Coach – who only has so many buses. This was evident during Hurricane Rita.

- There is not much that can be done to be resilient to surge, especially in coastal zip-zones. General council won't allow facilities to shelter in place if mandatory evacuation has been decided on.
 - How do we make sure these patients are accounted for?
 - Best practices differ across different fields
- **3 Issues to keep in mind during next hurricane:**
 - Waste
 - Extra container for trash, waste delivered in the event of emergency. Arranged for in advance via contract.
 - Is there some type of emergency plan for addressing waste?
 - Electricity/ Power Restoration
 - Complexes side by side regain power at different times. Getting in touch with the right officials is essential.
 - Having a generator on site is becoming a requirement. These contracts need to be arranged for in advance.
 - Water
 - Run all water through central
 - COLLECTIVE RESOURCE GUIDE!
- Implementing Emergency Plans
 - Backups for vendors essential
 - Issues with curfew – when healthcare workers are on street, holdups can occur
 - Universal credential system might be useful when curfews are in place

SCENARIO 3: BIOLOGICAL DISEASE OUTBREAK – PANDEMIC INFLUENZA

- Three main age groups: Children, Adults, Elderly
- Outbreaks occur in waves – 3 serious weeks of infection
- Surge capacity issues
- We live in a global world and the concept of containing a disease within a certain country or continent is no longer feasible
- All non-pharmaceutical interventions will be considered – closing down public venues, social distancing, quarantining, and communication to public at large – including companies, employers, private and public agencies. Non-pharmaceutical interventions need to be communicated as precautions beforehand.
- Are communication channels already established?
 - Email addresses of staff in directory, call-in number for outside questions,
 - Communication with local health departments – many agencies have infection control nurses who relay outside information to the agency
 - What is the most reliable source for these nurses to get information?
 - Health Alert Network – Harris County HAN
 - Does Galveston/ Clear Lake have a similar system?

- ILI
- What can be done for people if hospitals are overwhelmed? Do our roles become that of an alternate care provider to a hospital? These concepts and roles were being developed during H1N1.
- Would other agencies be interested in looking at alternate standards? Should different levels of precaution be taken (infection control measures)? Each individual facility will not alternate its standards of care – that’s an official term. Perhaps another term should be used. It needs to be determined what this will be.
- We need to create protocols for if the patient needs to stay in their home as opposed to seeking official emergency care.
- Some measures taken during NORA(??) virus by healthcare facilities worked relatively well – including waiving food fees to avoid contact with patients, and allowing sick nurses to receive pay regardless of whether they went into work or not
- What is understood as MEDICARE recommendations might actually be ACIP (American Committee of Immunization Practices) recommendations. Medicare website speaks of the large number of pneumonia regardless of vaccine – many are not aware of its availability. Some patients are hesitant to take vaccines or anti virals.
- Accessing staffing resources if alternate facilities are set up – sister communities in other cities help with shortfalls
- Accessing bed capacity – do we need to set up a process for tracking and reporting bed usage? How frequently does DADS reporting take place? Sick and well beds available? System for alleviating stress on facilities over capacity? Reimbursement is an issue for facility trying to claim on a bed, there is no standard for free beds – standards come with money.
- Ventilators, ask the board of nursing

SCENARIO 2: BIOLOGICAL ATTACK – AEROSOL ANTHRAX

- If you don’t get prophylaxis very quickly, you will get infected
- 99% of those untreated will die
- If you get antibiotics to the exposed persons within the first 48 hours, there’s a high chance that the person will survive it. If not, YOU’RE DEAD.
- Our mandate is--- you have to get the population prophylaxed within the first 48 hours
- Simple explanation – we need to get pills into the hands of people exposed (and potentially exposed). Re-exposure likely, when contact with spores occur. First signs – people show up in hospitals with symptoms. If it takes 10-14 days to start seeing symptoms, the prognosis is very poor. Ciprofloxacin, doxycyclin are antibiotics to treat anthrax.
- If we were to tell you we were going to have to mass prophylax the residents of this city, would you be able to ensure that your patients receive the required pills?
- Public clinic POD sites will be in action – closed POD sites
- One solution might be for you to report to a POD and we’ll have an allocated box for you – as opposed to a closed POD

- 2 way communication and reporting – ensure that systems are in place to push information to healthcare providers – essential
- There will be other aspects beyond the original administration of prophylaxis
- Ventilator tracking may be critical to monitoring
- We use a head of household model – one member of family may get meds for entire family
- 60 days worth of antibiotics exist – given in ten day regimens

PRIORITIES for LTCHHEMC

- The group voted on issues that were identified during the gap analysis session and came up with the following ranked priorities:

<i>Item</i>	<i>Priority Ranking (Highest to lowest)</i>
Sharing Session for Best Practices/Lessons Learned	10
Distribution/Dispensing system for bioterrorism/communicable disease outbreak	8
Memorandums of understanding/Memorandums of Agreement	8
Triggers and protective measures for infection control	7
Resource guide/ power restoration/ waste disposal	7
Health Alert Network (HAN) and communications	6
Credentialing/Badging for employees	5
Matching RNs & durable medical equipment (DME) providers to shelters/continuum of care for patients	5
Nurse delegation of duties/ insulin injections and use of ventilators	4
Bed reporting	4
HR policies and resource sharing	3

Next LTCHHEMC Meeting

- The group discussed and decided to keep the meeting monthly, except for November and December.
- Next Meeting: Friday, October 28th, 2011 1:30PM-3:30PM at HDHHS Lab Media Room
 - Use list-serve to share relevant information
 - If you have materials you need copied for the meeting send to John via email. LTCHHEMC@houstontx.gov
 - Any resources provided will also be posted to the website: <http://www.houstontx.gov/health/cohcommunity/LTCHHEMC.html>
- After October meeting next meeting will be in January 2012